

TESTIMONY

of the

AMERICAN ACADEMY OF PEDIATRICS

Submitted for the Record of the Hearing Before the
Committee on Energy and Commerce
September 8, 2005

“Medicaid: Empowering Beneficiaries on the Road to Reform”

The American Academy of Pediatrics (AAP) is an organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists, who are deeply committed to protecting the health of the 27.8 million children and adolescents who receive health care throughout the Medicaid program.¹

The Academy would like to provide comments on some of the proposals being discussed regarding changes to the Medicaid program. Additional AAP policy on Medicaid can be found in our Medicaid Policy Statement, which is attached.

Benefits Package

The Academy believes benefits for children in the Medicaid program must not be compromised – reducing or eliminating health care services for children unnecessarily places children at significant health risk. Children represent over 50% of all Medicaid enrollees, but they account for less than 25% of all Medicaid expenditures – including expenditures for children with special health care needs.²

Preventive care is the cornerstone of pediatrics. The value of preventive care in the Medicaid program has been sustained and promoted since its inception. Emphasizing preventive care for children and adolescents is a strong investment in our nation's future and must be maintained.

In Medicaid, preventive care is guaranteed through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Maintaining EPSDT ensures that illnesses are identified early, immunizations are not delayed, and that there is appropriate monitoring of early childhood development. We know from recent data that adherence to well-child care recommended visits is effective at lowering the risk of emergency department (ED) use and the risk of avoidable hospitalization.³ Identifying and treating conditions early prevents further complications and more serious illness in the future, which is more costly to treat.

The EPSDT protection is vitally important, however, not only in assuring that children and adolescents receive needed preventive services, but that they also receive the full range of medically necessary diagnostic and treatment services they need. Moreover, we strongly support policies that would encourage the availability of the services of primary care pediatricians, pediatric medical subspecialists, pediatric surgical specialists, developmental and behavioral service providers, care coordinators, and hospitals with appropriate pediatric expertise. Such services should be provided through the medical home, as defined by the AAP.

A medical home is not a building, but is defined as primary health care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. In a medical home, a pediatric clinician works in partnership with the family/patient to assure that all medical and non-medical needs of the patient are met. Through this partnership, the pediatric clinician can help the family/patient access and coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the child/youth and family.

The National Governors Association has recommended that states be allowed the flexibility to tailor benefits packages for specific populations. We are very concerned that such flexibility would lead to erosion of the EPSDT benefit and other important benefits for children.

Preventive care through Early and Periodic Screening, Diagnosis and Treatment (EPSDT) must continue to be protected for children. Undermining the guarantee of the EPSDT benefit provided to children would have a devastating, long-lasting and negative effect on the health of low-income children nationwide. EPSDT ensures that illnesses are identified early, immunizations are not delayed and that there is appropriate monitoring of early childhood development. Moreover, prevention, early intervention, necessary treatment, and care management through a medical home often *save* money by reducing the need for emergency and acute care, and reducing the likelihood of long-term complications.

Cost Sharing -- In General

Access to affordable needed comprehensive health care benefits and services is vital to providing a safety net for low-income children and children with special health care needs. We know from evidence – including two new reports from the Kaiser Family Foundation and the Center on Budget and Policy Priorities⁴ – and experience in states that have instituted cost sharing in other programs, that cost sharing can prove to be a significant barrier to health care. Existing cost sharing protections ensure that children and pregnant women are not prevented from accessing needed health care services and medications because of inability to pay.

The Academy is concerned that changes to cost sharing policies for children would drastically affect the ability of children to obtain needed care. Medicaid must maintain the policy prohibiting cost sharing on all Medicaid benefits for children and pregnant women, especially for preventive care, which is the most likely to be neglected if not affordable.

Tiered Co-payments for Prescription Drugs

While we understand the need to control the cost of prescription drugs in the Medicaid program, it is vital that efforts to control prescription drug spending are not simply placed on the backs of children. In federal fiscal year 2000, children represented 54.6% of all Medicaid enrollees, but accounted for only 22.9% of prescription drug expenditures in the program.⁶

Children are not the drivers of prescription drug expenses in Medicaid. No prescription drug control should in any way limit the ability of a child to obtain the medication he or she needs.

Under current law, states may not impose any co-payments for prescription drugs provided to children under age 18 or to pregnant women. For other populations, only “nominal” co-payments may be charged. At present, “nominal” is set by regulation as \$3.00 in most cases. Under current law, co-payments are not “enforceable,” meaning that treatment or medication cannot be denied if the patient is unable to provide the co-payment.

The National Governors Association (NGA) and the Medicaid Commission have proposed that states be permitted to institute “tiered co-payments” for prescription drugs, so that they can charge more for “non-preferred” drugs than for “preferred” drugs (those for which the state has negotiated a favorable price). For beneficiaries at or below the federal poverty line – including children and pregnant women – “nominal” co-payments on “preferred” drugs could be imposed. All co-payments would become “enforceable.”

There are several reasons why this proposal is problematic for children and pregnant women, even those whose family incomes are above the federal poverty level.

First, an “enforceable” co-payment would mean that a needed drug might be withheld if the patient cannot produce the co-payment at the time the prescription is picked up. In many low-income households, including those above the poverty level, people live from paycheck to paycheck. If they need a prescription when they are short on cash, and do not have credit available to them, they may have to go without, or delay taking, the prescribed medication, even if the co-payment is only “nominal.” This could cause dangerous complications in many cases. For pregnant women, foregoing or delaying needed medications would also create health risks for her unborn child.

Moreover, even a “nominal” payment for can erect a barrier when a family must get medication for more than one child, as in the case of an infectious disease that has spread through the family or a chronic disease affecting more than one child.

Co-payments for prescriptions drugs would also create problem for individual children who need multiple drugs, as do many children with chronic illness or disabilities. If a child needs several medications daily, then even “nominal” co-payments can quickly become prohibitive. Again, this danger is exacerbated if more than one child in the family needs multiple medications, which is not uncommon in the case of asthma or other inheritable conditions.

The NGA and Medicaid Commission proposals envision that states would have “broad authority” to waive co-payments in “unique circumstances and cases of true hardship” (NGA) and “in cases of true hardship or where failure to take a non-preferred drug might create serious health effects” (Medicaid Commission).

These exceptions do not afford adequate protection, however. It may be difficult for a family to access these protections, and waivers or prior authorizations may take too long to obtain. As a result, a child may be forced to take a “preferred” drug that is not as effective. This could be a particular problem for children with certain chronic conditions, such as epilepsy or mental illness, for whom it may have taken months or years to ascertain the most effective combination of medications to control their condition and/or minimize adverse side effects. If one of their drugs is deemed “non-preferred,” and thereby becomes cost-prohibitive, then their medication regimen may be thrown into turmoil.

Adequate Medicaid Payment

The issue of low payment in Medicaid is one that has plagued the program for years. On average, Medicaid reimburses pediatricians at only 69% of the rate that would be paid under Medicare, and only 56% of commercial rates for an office visit.⁵ In some states, Medicaid payment is even lower. Such low reimbursement impedes access to quality health care. Low Medicaid payments do not cover costs, and increasingly force pediatricians to make difficult business decisions of continuing to treat patients at a financial loss, or limiting their participation in the Medicaid program altogether. The resulting lack of access for patients then drives them to seek expensive emergency room care. Moreover, low Medicaid reimbursement endangers the economic viability of “safety net” providers, thereby fragmenting the care received by children in Medicaid, and undermining access to specialty care for all children, as when a Children’s Hospital or clinic is forced to close or reduce services.

While a number of states have taken steps to increase Medicaid reimbursement rates to match those of Medicare, most have not. Any discussion of restructuring Medicaid must include steps to appropriately reimburse physicians for the care they provide children under the Medicaid program.

Enhancing Quality and Controlling Costs in the Overall Health Care System

Pediatricians applaud efforts to enhance state Medicaid quality-improvement activities for children. Such quality improvement measures should include: quality-performance measures by states to address access to care, utilization, effectiveness, and satisfaction related to preventive, primary, acute and chronic care for children; appropriate incentives; uniform and consistent EPSDT reporting with minimal paperwork burden on providers; and use of the Consumer Assessment of Health Plan Survey (CAHPS) for a representative sample of children enrolled in state Medicaid programs, especially children with special health care needs.

There should also be programs to improve the quality of pediatric care as well as tools and measures to monitor changes, especially the provision of medical homes for children with special health care needs; updated meaningful provider-assessment and –certification activities; partnership with other state agencies, such as Title V offices, to support practice-level improvements in pediatric care; the monitoring of enrollment patterns and reasons for enrollment changes; implementation of general administrative review processes to ensure managed care organizations and behavioral health organizations are qualified and available; and timely, linguistically appropriate, meaningful results of quality-related activities to beneficiaries to facilitate their participation in health care decision-making.

Improving Access to Home- and Community-Based Care

We strongly recommend that Medicaid maintain eligibility, coverage, and access for children with special health care needs through home- and community-based services waivers and Katie Beckett programs.

Improving Chronic Care Management

Children with special health care needs are a unique group of children in Medicaid, and require specific treatments and systems that address their exact needs. The pediatric community strongly recommends that care for children with special health care needs be provided in a medical home. Moreover, states should develop policies that encourage care coordination, with direct involvement by the primary care pediatrician within a medical home. Such care coordination links children with special health care needs and their families to services and resources in a coordinated effort to maximize the potential of the children and to provide them with optimal health care.

Care coordination is often complex, and faces many barriers. With federal support, states should offer incentives to identify children with special health care needs and offer providers enhanced payments for providing a medical home that provides primary care combined with family education, practice-based care coordination, and transition to adult care. States should also implement special planning and oversight of the use of managed care for children with special health care needs, including children in foster care and children with mental health conditions. This should cover benefit specifications for specialty or chronic care services, composition of pediatric provider networks, policies for flexible service authorization, care coordination, quality-performance measures for preventive care delivery for children with various types of chronic conditions, family participation, pediatric risk-adjustment mechanisms, and other financial incentives for high-quality care.

Comprehensive Waiver Reforms

The Academy understands the desire by states to streamline the process for obtaining waivers to federal Medicaid law, or for allowing changes to programs without the use of waivers. However, we are concerned with any proposal to allow for waivers or other changes to Medicaid without the appropriate input of all stakeholders in Medicaid, as well as safeguards to ensure that states do not unnecessarily deny care to children. In recent years, some state waiver proposals have initially failed to provide full details. Moreover, in some instances, states have been hesitant to allow for the necessary feedback from all Medicaid stakeholders. It is therefore very important that any effort to streamline the waiver process be balanced with the need to provide minimum standards, adequate protections for health care for children, and appropriate input from all Medicaid constituents.

Judicial Reforms

Since the Medicaid program is a federal-state partnership, and states are the administrators of Medicaid, it is understandable that states require full operational authority over their Medicaid programs. However, it is critical that such programs meet the basic standards outlined by federal Medicaid law and that adequate protections for children are in place. Without the ability to seek enforcement of federal standards, federal Medicaid law in essence becomes a series of “suggestions.” The legal system provides the only real recourse to seek enforcement when states drastically fall short of federal standards. This last safety net ensures that enrollees receive the care to which they are entitled under the program, and must not be compromised. While acknowledging the right of states to make operational changes, we do not feel that such changes should be allowed to break federal Medicaid law or fall short of federal standards set by Congress. The Academy therefore recommends that any proposal to restructure Medicaid does not impede the ability of those involved in the program to ensure that children receive the care to which they are entitled, including through the courts if necessary.

In closing, the American Academy of Pediatrics seeks to ensure that Congress keeps foremost in mind the 27.8 million children served by Medicaid as it considers restructuring the program. Together with the State Children’s Health Insurance Program (SCHIP), Medicaid is this country’s only and vital safety net for children. Medicaid provides health insurance to nearly one-third of children in the United States, and it is essential that any restructuring of Medicaid not undermine protections for them in the program. Children have no means of obtaining health insurance on their own – in those instances where children are eligible for Medicaid, it is their sole means of assuring their health. We must not compromise children’s health in the name of reform.

We would be happy to provide any information or input the Committee might need as it considers changes to this critical program for children.

¹ Medicaid Statistical Reports (MSIS/2028 Reports) for Federal Fiscal Year 2002. *Centers for Medicare and Medicaid Services*.

² AAP 2002 Medicaid State Reports, based on CMS/MSIS2082 data. *American Academy of Pediatrics*.

³ Hakim R, Bye B. Effectiveness of Compliance with Pediatric Preventive Care Guidelines Among Medicaid Beneficiaries. *Pediatrics*. 2001; 108:90-97.; Hakim R, Ronsaville D. Effect of Compliance with Health Supervision Guidelines Among US Infants on Emergency Department Visits. *Archives of Pediatrics and Adolescent Medicine*. 2002; 156: 1015-1020.

⁴ Ku L. The Effect of Increased Cost-Sharing in Medicaid: A Summary of the Findings. May 31, 2005. *Center on Budget and Policy Priorities*.; Artiga S, O’Mally M. Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences. May 2005. *Kaiser Commission on Medicaid and the Uninsured*.

⁵ Zuckerman et al. Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation. *Health Affairs Web Exclusive*. June 23, 2004.; 2002 Pediatric Medical Cost Model. *American Academy of Pediatrics*.